

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02693

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Kent</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Sunderville</u> COUNTY <u>Garne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural; Chestertown</u> <u>Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sunderville, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Walter</u> (Last) <u>Boyles</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> , <u>8</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <del>SINGLE</del> , MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-29-1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Latic Corp</u>	9. AGE last birthday <u>25</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Harvey Boyles</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (service) <u>W. War 2</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Casey</u>	
16. SOCIAL SECURITY NO. <u>25-70-4767</u>		17. INFORMANT <u>Mrs. Clarence Marvel, Warton, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Probable <del>trauma</del> in cervical spinal cord injury</u>		<u>instantaneous</u>
Antecedent cause(s) (b) <u>Probable gliosarcoma or fracture dislocation of C 6</u>		<u>instantaneous</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Possible alcoholic intoxication. (Spinal fluid sent to Chief Medicine Examiner)</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>Street</u>	(CITY OR TOWN) <u>Chestertown (Rural)</u> (COUNTY) <u>Kent</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>18</u> <u>1957</u> <u>2</u> <u>PM</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Auto mobile accident</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>R. W. Farr</u> M.D. <u>Chestertown, Md</u>		DATE SIGNED <u>3-18-57</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>March 21, 1957</u>	<u>Sunderville</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>Mar 21, 1957</u>	<u>Frank H Smith</u>	<u>Edward Fellows, Millington, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED  
JUN 28 1961

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02694

Reg. Dist. No. 200

1. PLACE OF DEATH COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GALENA</u>	
TOWN <u>GALENA</u>		TOWN <u>GALENA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>EMMA</u> (Last) <u>BRAMBLE</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 9, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE THOMAS BRAMBLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY DILLIHUNT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>ROBERT N. BRAMBLE GALENA, MD.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac Failure</u>			<u>3 months</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>			<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/2, 1951, to 3/18, 1951, that I last saw the deceased alive on 3/8, 1951, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE Robert E. Emmer, M.D. ADDRESS Chesterstown, Md. DATE SIGNED 3/20/51

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>March 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>GALENA CEMETERY</u>	LOCATION (City, town, or county) <u>GALENA</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>March 20, 1951</u>	REGISTRAR'S SIGNATURE <u>Elizabeth J. Mulford</u>	24. FUNERAL DIRECTOR <u>Edward Fellows</u>	ADDRESS <u>Millington, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02695

## CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH COUNTY <u>Kent co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Betterton md</u> TOWN <u>Betterton md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Betterton</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u> TOWN <u>Betterton</u> STREET ADDRESS _____ (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Elmer</u> (Middle) <u>Brice</u> (Last)	4. DATE OF DEATH Month <u>Mar</u> Day <u>8</u> Year <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 8, 1914</u>
9. AGE last birthday <u>37</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering</u>	11. BIRTHPLACE (State or foreign country) <u>Betterton Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Brice</u>	14. MOTHER'S MAIDEN NAME <u>Helen Elizabeth Brice Crew</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	16. SOCIAL SECURITY No. <u>219-05-4702</u>	17. INFORMANT <u>George Brice</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Myocardial Infarction</u>			
(b) Antecedent cause(s) <u>Not Known</u>			
(c) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>- X</u>			
19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>✓</u>	(CITY OR TOWN) <u>✓</u>	(COUNTY) <u>✓</u> (STATE) <u>✓</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Patient had just expired</u>	
22. I hereby certify that I attended the deceased from <u>last summer</u> , 19 <u>50</u> , to <u>super my arrival</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>51</u> , and that death occurred at <u>2:30 pm</u> , from the causes and on the date stated above.			
SIGNATURE <u>James Edwin Hedeman MD</u>		DATE SIGNED <u>3/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Still Pond. md</u>	LOCATION (City, town, or county) <u>Betterton md</u>
DATE REC'D BY LOCAL REG. <u>3/11/51</u>	REGISTRAR'S SIGNATURE <u>E. Howard Jones</u>	24. FUNERAL DIRECTOR <u>B. R. Fellows md.</u>	

092898

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 Front Street</u>		MARYLAND LENGTH OF STAY (in this place) <u>18 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> OR TOWN STREET ADDRESS (If rural, give location) <u>118 Front Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Catherine Clark</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>March 12 1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>December 1, 1867</u>		9. AGE last birthday <u>83</u> yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Perry County, Missouri</u>	
13. FATHER'S NAME <u>Joshua Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Irwin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mrs. Gilbert Mead, Chestertown, Md</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Chronic myocarditis and myocardial degeneration

INTERVAL BETWEEN ONSET AND DEATH

10 years

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

Coronary artery disease8 yearsArteriosclerosis10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 1, 1950, to March 12, 1951, that I last saw the deceased alive on March 12, 1951, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

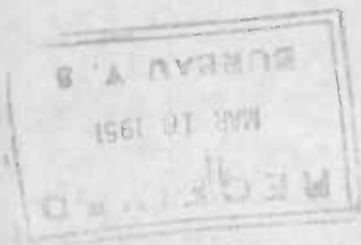
ADDRESS

DATE SIGNED

23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/16/51</u>		NAME OF CEMETERY OR CREMATORY <u>W.D. Chestertown, Maryland</u>		LOCATION (City, town, or county) (State) <u>Perryville, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>March 14-1951</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02697

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		MARYLAND LENGTH OF STAY (in this place) <u>life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md.</u> STREET ADDRESS (If rural, give location) <u>408 High St.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>ANN</u> (Middle) <u>DODD</u> (Last)		DATE OF DEATH <u>3</u> / <u>25</u> / <u>1951</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Oct. 23, 1879</u>	9. AGE last birthday <u>71</u> yrs.	10. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown</u>	
13. FATHER'S NAME <u>William H. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Louise Lambert</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Dr. Harry L. Dodd - Same address</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <u>400.1</u>		(a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
Antecedent cause(s) <u>940</u>		(b) <u>Generalized arteriosclerosis</u>		<u>years</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/25</u> , 19 <u>51</u> , to <u>3/25</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>51</u> , and that death occurred at <u>11 A</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Robert E. Esser, M.D.</u>		(Degree or title)		ADDRESS <u>Chestertown, Md.</u> DATE SIGNED <u>3/25/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 28, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u> LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 27-1951</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02698

Reg. Dist. No. 200

1. PLACE OF DEATH COUNTY <u>SASSASSFRAS</u> <u>RIENT CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>63 YEARS</u> COUNTY <u>SAME</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>SASSASSFRAS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) _____	
TOWN _____		TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) <u>LENA</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>24</u> (Year) <u>1957</u>	
(First) _____ (Middle) <u>GRISSETT</u> (Last) _____			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Domestic</u>	8. DATE OF BIRTH <u>Oct 19, 1862</u>
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Refermann</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Phillip Belm - Sassassfras, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic myocarditis</u>		<u>2 weeks</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>		<u>2 weeks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) _____	PLACE (Home, farm, factory, street, OF office bldg., etc.) _____	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
HOMICIDE _____	INJURY _____	
TIME (Month) (Day) (Year) (Hour) OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Mar 10, 1957, to Mar 24, 1957, that I last saw the deceased alive on Mar 24, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

March 25, 1957Edward FellowsEdward Fellows, Millington, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02699

Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salts</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salts</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>VIOLA</u>	(Middle)	(Last) <u>HARRIS</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 9/18/96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>54</u> yrs.	4. DATE OF DEATH <u>March 30</u> 19 <u>57</u>
11. FATHER'S NAME <u>Alexander Manton</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. MOTHER'S MAIDEN NAME <u>Hensley unknown</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT'S NAME <u>Edward Harris</u>		17. ADDRESS <u>Salts md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>apoplexy</u>			<u>12 days</u>
Antecedent cause(s) (b) <u>Hypertensive Heart Disease</u>			<u>many years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.		INJURY OCCURRED While at <u>Not While</u> At work <u>At work</u>	
HOW DID INJURY OCCUR? <u>—</u>			

22. I hereby certify that I attended the deceased from 3/16, 1957, to 3/28, 1957, that I last saw the deceased alive on 3/28, 1957, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

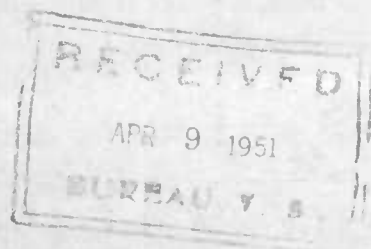
SIGNATURE (Degree or title) J. H. Hamilton ADDRESS M. D. Millington md. DATE SIGNED 4/3/57

23. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>	DATE <u>April 3/1957</u>	NAME OF CEMETERY OR CREMATORY <u>New Bethel Cemetery</u>	LOCATION (City, town, or county) <u>Salts</u> (State) <u>md.</u>
DATE REC'D BY LOCAL REG. <u>April 2, 1957</u>	REGISTRAR'S SIGNATURE <u>Edward G. Bellows</u>	24. FUNERAL DIRECTOR <u>Edward G. Bellows</u>	ADDRESS <u>Millington md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02700  
Reg. Dist. No. 203.

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Skinner neck</u>		STREET ADDRESS (If rural, give location) <u>Skinner neck</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>Edward</u>	(Last) <u>Higgins</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>11</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 29 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Kent Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Wm. Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda Beck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. James Higgins, wife</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>about 4 years</u>
(a) Immediate cause <u>Cancer of rectum</u>		
(b) Antecedent cause(s) <u>46d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>July 1947</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cancer of rectum</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3/8, 1949, to 3/11, 1951, that I last saw the deceased alive on 3/8, 1951, and that death occurred at 3:57 p.m., from the causes and on the date stated above.

SIGNATURE Robert G. Burgard M.D. ADDRESS Rock Hall, Md. DATE SIGNED 3/12/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>	LOCATION (City, town, or county) <u>Rock Hall Kent Md.</u>
DATE REC'D BY LOCAL REG. <u>3/13/51</u>	REGISTRAR'S SIGNATURE <u>S. Elwood Burgess</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane - Bethesda Hill Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

910126



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
in 9 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02701

FILM No. G 1 MAR 21 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent &amp; Queen Anne's co. Hwy. N. 1/2</u>		STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (First) <u>JANE</u> (Middle) <u>M.</u> (Last) <u>NELSON</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Mar. 19, 1892</u> 9. AGE last birthday <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Don't Know</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE L. MANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Rev. John M. Nelson</u>			

18. MEDICAL CERTIFICATION		Interval BETWEEN ONSET AND DEATH <u>20 hrs.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>			
94a Antecedent cause(s) (b) <u>None</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/10</u> , 19 <u>51</u> , to <u>3/11</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/11</u> , 19 <u>51</u> , and that death occurred at <u>3:20 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert E. Ennor, M.D.</u>		ADDRESS <u>Chestertown, Md.</u> DATE SIGNED <u>3/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 13, 1951</u> NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u> LOCATION (City, town, or county) (State) <u>near- Chestertown, Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 12 - 1951</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u> 24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells Chestertown, Md.</u>	

093888



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02702 203

1. PLACE OF DEATH-COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED-STATE <i>Maryland</i> COUNTY <i>Kent</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall, Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main St</i>		STREET ADDRESS <i>Main St</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Emma</i>	(Middle) <i>Virginia</i>	(Last) <i>Rodney</i>
4. DATE OF DEATH	(Month) <i>March</i>	(Day) <i>20</i>	(Year) <i>1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2/17/1885</i>
9. AGE last birthday <i>66</i> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own house</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Schwartz</i>		14. MOTHER'S MAIDEN NAME <i>Emma Barnes</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>421.4</i>	
17. INFORMANT AND ADDRESS <i>Husband, Rock Hall, Md.</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) *acute pulmonary edema*

## Antecedent cause(s)

(b) *chronic sufo-myocarditis*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

*arthritis*

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1949*, 19....., to *3/20*, 19*51*, that I last saw the deceasedalive on *3/20*, 19*51*, and that death occurred at *4:25 p* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Albert A. Buzzard M.D.**Rock Hall**3/24/51*

## 23. BURIAL CREMATION REINTERMENT (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*March 23/51**J. Shwood Ingram**Edgar Lane Church Hill Md*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02703  
Reg. Dist. No. 203

1. PLACE OF DEATH COUNTY <u>kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>near Rock Hall</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Carrie</u> (Middle) <u>B.</u> (Last) <u>Sisco</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 26, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Warner</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Banks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>George Sisco - Rock Hall, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>ulcers of stomach</u>		<u>1 year</u>
Antecedent cause(s) (b) <u>54.0</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>117a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <input checked="" type="checkbox"/> INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/6, 1951, to 3/15, 1951, that I last saw the deceased alive on 3/15, 1951, and that death occurred at 11:10 p.m., from the causes and on the date stated above.

SIGNATURE Ed Karker M.D. (Degree or title) ADDRESS Rock Hall Md DATE SIGNED 3/16/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 18, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>	LOCATION (City, town, or county) (State) <u>near Rock Hall, Md.</u>
DATE RECD BY LOCAL REG. <u>3/12/51</u>	REGISTRAR'S SIGNATURE <u>S. Shivers Burgess</u>	24. FUNERAL DIRECTOR <u>J. Willis Wells - Chestertown, Md</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH - COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent Queen Anne's</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>E</u> (Last) <u>Stevens</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 21, 1874</u>
9. AGE last birthday <u>77</u> yrs.		10. AGE last birthday (If under 1 year) (Month) (Day) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Horticulture</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Clay Stevens</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA Booker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Hosp. Records</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Chronic myocarditis + degeneration

## INTERVAL BETWEEN ONSET AND DEATH

6 mos?

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Anterovascular(c) Congestive heart failure1 year14 days

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-26, 1957, to MARCH 24, 1957, that I last saw the deceasedalive on 3-23, 1957, and that death occurred at 6:10 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 26-1957Clara L. B.Edward Fellows Millington, Md.

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH- COUNTY <u>Pent</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Pent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Masses</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Masses</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) <u>MARY</u>		(Middle) <u>THOMAS</u>	
5. SEX <u>F.</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		8. DATE OF BIRTH <u>July 20, 1871</u>	
13. FATHER'S NAME <u>John Ross</u>		14. MOTHER'S MAIDEN NAME <u>Susan unknown.</u>		4. DATE OF DEATH <u>March 28</u> 19 <u>57</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>		9. AGE last birthday <u>79</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		17. INFORMANT AND ADDRESS <u>Edward Johnson, Masses, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Immediate cause (a) <u>Stroke</u>			
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			<u>years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>none</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at <u>Not While</u> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>

22. I hereby certify that I attended the deceased from 3/26/57, 1957, to 3/28, 1957, that I last saw the deceased  
alive on 3/27, 1957, and that death occurred at 11 A m., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
H. H. Hamilton M.D. Millington Md 3/30/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>March 31, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Millington Ceme.</u>	LOCATION (City, town, or county) <u>Millington</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>March 30, 1957</u>		REGISTRAR'S SIGNATURE <u>Edward Bellows</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edward Bellows, Millington, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

720836



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02706

Reg. Dist. No. 203

1. PLACE OF DEATH- COUNTY Kent MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Kent	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Rock Hall		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Barbara A. Wood		4. DATE OF DEATH (Month) (Day) (Year) Mar 21, 1951	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 4, 1876
9. AGE last birthday 74 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Harsh	
14. MOTHER'S MAIDEN NAME not known		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no	
16. SOCIAL SECURITY No. no		17. INFORMANT AND ADDRESS Emmett Wood (son) Rock Hall, Md.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
153 Immediate cause (a) Secondary Cancer			
462 Antecedent cause(s) (b) Carcinoma of Intestine			Feb-50
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION Oct. 21/50		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Basal. of Cervix	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec. 15, 1950, to Jan. 1, 1951, that I last saw the deceased alive on Mar. 5, 1951, and that death occurred at 3 A.M., from the causes and on the date stated above.

SIGNATURE Frank W. Lantz		ADDRESS Chestertown Md		DATE SIGNED March 21/51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Mar. 23, 1951	NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	LOCATION (City, town, or county) Rock Hall, Md.	(State)
DATE REC'D BY LOCAL REG. 3/21/51	REGISTRAR'S SIGNATURE J. Elwood Briggs	24. FUNERAL DIRECTOR J. Willis Wells- Chestertown, Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 28 1961  
BUREAU A. S.